An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0101
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim - pre-existing condition
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant held a travel insurance policy with the Provider.

The Complainant's Case

The Complainant submits that she was taken ill while on holiday abroad and was admitted to hospital on **6 October 2019** suffering from breathing difficulties and coughing. She says that, while hospitalised, certain treatments and investigations were advised. She contends that she underwent chest x-rays and scans, and that these investigations showed that the treatments required included mechanical ventilation, intubation and arterial catheterisation.

The Complainant states that her hospital bill came to a total of STG£17,750.00, of which she has paid STG£9,500.00, leaving an outstanding balance of STG£8,250.00.

The Complainant submitted a claim for her medical expenses to be paid by the Provider pursuant to a policy of travel insurance that she held with it, but the Provider has declined her claim. The Complainant would like her claim to be accepted and for her medical expenses from her treatment abroad to be paid by the Provider.

The Provider's Case

The Provider says that the Complainant as the holder of an account with an e-money provider, was eligible to upgrade, so as to include travel insurance cover at a monthly cost. The Provider says that the upgrade in question was

> "*done through the accountholder's [e-money provider] app on their mobile phone*. *All terms and conditions are available for review prior to and post completing the upgrade via the accountholder's [e-money provider] app.*"

In its Final Response Letter, dated **13 March 2020**, the Provider states that the Complainant's claim for policy benefits, was excluded from cover because the treatment she underwent abroad was for a "*pre-existing medical condition*", as defined within the policy terms and conditions.

The Provider notes that the Complainant's medical records indicate that she had a history of COPD (Chronic Obstructive Pulmonary Disease), Ischaemic Heart Disease and Hypothyroidism, and it lists the medications which had been prescribed to the Complainant.

The Provider says the policy terms which provide for exclusions of cover in certain circumstances. It explains that travel insurance policies do not cover every eventuality, and rather the cover is subject to the limitations of the policy. It states that, while it is sorry that the Complainant was sick and wishes her a full recovery, it is not in a position to pay the Complainant's claim.

The Complaint for Adjudication

The complaint is that the Provider wrongfully declined to admit and pay the Complainant's claim under a travel insurance policy for the cost of medical treatment she received abroad.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint. Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

/Cont'd…

A Preliminary Decision was issued to the parties on **26 March 2021**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter. In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

The Complainant held a policy of travel insurance with the Provider which was incepted on **12 August 2019**. I note that the Provider says that the Complainant acquired this cover, by virtue of being the holder of an account with an e-money provider. It seems that she was eligible to an "upgrade" so as to include travel insurance cover, at a monthly cost to her. I note that this "upgrade" was

> "*done through the accountholder's [e-money provider] app on their mobile phone*. *All terms and conditions are available for review prior to and post completing the upgrade via the accountholder's [e-money provider] app.*"

In this regard, I note that the e-money provider was the policyholder and the Complainant was a beneficiary, once she implemented the upgrade to purchase the travel insurance cover.

The Complainant went on holiday to [location]. The holiday was due to run from **25 September 2019** to **9 October 2019**. While in [location], the Complainant fell ill and went to hospital. The hospital records indicate that the Complainant was first seen on **5 October 2019** but was not admitted as a patient.

On **6 October 2019** the Complainant was admitted to hospital in [location]. Her diagnosis was *"Bilateral Pulmonary Emboli*[sm]" *"Pneumonia" "COPD"*. She remained under the care of the doctors in hospital in [location] until **22 October 2019**, and for significant period of time her treatment took place in the hospital's intensive care unit. Neither the Complainant nor her partner contacted the Provider, prior to seeking medical treatment abroad. At the end of the hospital stay, the Complainant's partner contacted the Provider to advise it of the situation. The Provider procured reports from the hospital abroad and from the Complainant's GP.

The GP report dated **25 October 2019** consists of a form that is to be filled out by a customer's treating physician. In response to the question:

> *"In the last 24 months had the patient any systemic, chronic or recurring illnesses that required treatment?"*

the Complainant's GP circled *"**YES**"* and elaborated:

> *"IHD; COPD; Hypothyroidism"* (Ischaemic Heart Disease; Chronic Obstructive Pulmonary Disease; Hypothyroidism)"

/Cont'd…

I note that the Complainant's GP also ticked *"**YES**"* alongside boxes, to indicate a history of cardiac disease, pulmonary disease and endocrine disease, and confirmed that the patient was aware of these conditions. A repeat medication list from the Complainant's GP dated **1 November 2019** contains a list of medications used for the treatment of her cardiovascular conditions, hypothyroidism, and pulmonary issues.

The Provider has stated that the terms and conditions within the policy documents made available for the Complainant to review, were clear and complied with Provision 4.1 of the Consumer Protection Code 2012.

I note in that regard that the Complainant's travel insurance policy provides cover against certain specified events which are set out in the policy wording. There are also conditions, restrictions, or exclusions which might apply to the cover put in place.

For a valid claim to arise it must be shown that one of these specified events has resulted in the claim being submitted, and is not subject to any condition, restriction or exclusion that may apply to the policy.

I note the heading in a Policy Summary document for the Complainant's policy:

What is Insured? and the green tick beside

> "***Emergency Overseas Medical Assistance and Expenses:*** *If you fall ill or suffer an injury whilst on your trip, we will pay up to £15,000,000 for your emergency medical expenses and transportation costs..."*

Under the heading ***What is not Insured?*** there is an "X" beside

> *"Any Pre-existing medical condition(s) that are not listed under "Acceptable Medical Conditions" on page 14 of the group policy wording"*

The Group Policy Wording Document defines ***Pre-Existing Medical Condition*** as:

> *"any past, current or reoccurring **Medical Condition**, or set of symptoms whether these have been diagnosed or not, that have been investigated or treated at any time, even if this condition is considered to be stable and under control".*

Medical Condition is defined as *"**Serious Illness** or **Bodily Injury**".*

Serious Illness is defined as *"any disease, infection or **Bodily Injury** which unexpectedly manifests itself for the first time during **Your Trip**.*

/Cont'd…

The policy document contains the following exclusion:

> *"**We** will not pay for claims which are in any way related to any **Pre-Existing Medical Condition** which existed either*
> – *at the time of taking out this insurance and / or*
> – *at the time of booking a **Trip** and / or*
> – *at the start of any **Trip***
> *unless **Your Pre-Existing Medical Condition** is confirmed in the list of Acceptable Medical Conditions shown below.*
>
> *There is no cover under this policy for any **Pre-Existing Medical Conditions** not listed in the list of Acceptable Medical Conditions..."*

There follows a list of 40 conditions. I note that none of the pre-existing medical conditions identified by the Complainant's GP (Ischaemic Heart Disease; Chronic Obstructive Pulmonary Disease; or Hypothyroidism) are included in the policy list of Acceptable Medical Conditions.

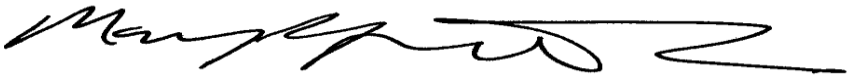
Although the policy placed an onus on the Complainant to contact the Provider prior to undergoing treatment abroad (or if this is not possible, the Complainant's companion to make contact it as soon as possible), the Provider has not sought to rely on this clause. I accept that this clause is not relevant, because the policy wording clearly states that the Provider will not pay a claim for treatment arising out of a pre-existing medical condition, as happened in this instance.

I am satisfied that the treatment the Complainant had to undergo whilst abroad, arose out of her pre-existing medical conditions that were not listed as an Acceptable Medical Condition within the policy. Accordingly, the policy offered the Complainant no cover for those conditions, whilst she was abroad. Whilst I sympathise with the Complainant, who suffered serious and life threatening illness whilst abroad, nevertheless, I must accept that the Provider was entitled to decline cover for the Complainant's claim and accordingly, the complaint cannot be upheld.

Conclusion

My Decision pursuant to **Section 60(1)** of the **Financial Services and Pensions Ombudsman Act 2017**, is that this complaint is rejected.

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.



MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

21 April 2021

/Cont'd…

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address,

and

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.